HEALTH CARE: A CORPORATE PERSPECTIVE*

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IT is most encouraging that in preparing this symposium on training tomorrow's physicians, the New York Academy of Medicine has considered it important to include the views of the public, including those of the business community.

The health of its employees and their families is an important matter to the Bell System, for which we expend a significant portion of our payroll. The opportunity to discuss the subject under the Academy's auspices is, therefore, most welcome. I shall not be reticent about sharing our views with you. In fact, I should probably tell you that, since I have both a son and son-in-law who are physicians, I have had a fair amount of practice in giving advice to physicians.

Were we meeting in a country other than the United States, it is likely that our main focus in this discussion would be on the inadequacies of health care—long waits for hospital beds, the unavailability of treatment for many non-life-threatening ailments, the disparity in treatment accorded different classes of citizens. Fortunately, in this country the availability and quality of health care are not overriding issues, though in some contexts they still are a matter of concern. Rather, what immediately comes to mind with the phrase "health care" are the companion words "cost containment."

Overuse of the phrase "cost containment" has diminished its impact somewhat. That is unfortunate, because the concept is important. It is critical in health care planning, whether by a federal agency formulating national health policy or a young couple thinking about having a baby.

A major health care insurer recently placed a full-page ad in the *Wall Street Journal* with a headline stating "Lowering The Cost Of Health Care

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Is #1 On Our Critical List." Of course, this is an issue of great importance to more than just the insurance industry. It should also concern state and federal governments, health care providers, employers, and individual citizens who are the buyers of health services. Currently, the cost of health care is one of the nation's knottiest problems, on a par with such issues as Social Security funding, military spending, and the deficit.

We have all heard the statistics. More than 10% of the gross national product is now spent on health care costs—an estimated $321 billion in 1982. The medical Consumer Price Index continues to rise at an annual rate well above the overall Index. Expenditures for Medicare and Medicaid rose from $26 billion in 1976 to $56 billion in 1981. Hospital stay costs are averaging $300 to $400 per day. On and on go the alarming statistics. I suspect that even those in the past who advocated more resources for medical care would now agree that we are approaching the limit.

In 1982 Bell System medical insurance premiums totalled $1.5 billion. We have experienced an average increase in medical insurance costs of about 15% per year since 1977, and this trend appears to be continuing. Expenses at such levels cannot be ignored. Some of the increase is due, in part, to improvements in our insurance plan coverage and to increased utilization by employees and their families. But, clearly, most of it results from escalating health service costs themselves—for example, hospital charges, ancillary services and physicians' fees. Relief is needed from these upward pressures on the cost of health care.

The question is, Where do we go from here? How should an employer respond to the difficult issue of doing something tangible about health care costs without endangering the quality of that care?

We at AT&T have decided that our policy must be to balance the quality of health care delivery with its cost. In defining our corporate role in this area, our benefit managers have established planning guidelines. They are: to assure that employees receive quality health care; to provide employees reasonable reimbursement for expenses associated with medically necessary care; to promote awareness among employees of good health habits and of the value of staying fit; to encourage the early detection of illness, as a preventive measure in avoiding more serious—and more costly—medical problems in the future; to provide employees with financial incentives for treatment alternatives that are less costly but medically sound; to protect employees from the heavy financial burdens

associated with serious, prolonged illness; and to require sharing by employees, as consumers of health care, of the costs associated with routine kinds of health services.

For purposes of our discussion, objectives can be grouped in three broad categories: first, effectively to design and administer medical insurance plans; second, to raise employees' health consciousness with regard to fitness, disease prevention, and costs; third, to collaborate with other health care interests.

With regard to medical insurance coverage, we need to escape the trap of automatically increasing reimbursement levels as charges increase. A conscious challenge to those provider increases must be made and can be achieved through the redesign of insurance plans. A reimbursement system that pays, without question, whatever is asked is imprudent. Accordingly, we see a need to shift from reimbursement based on so-called "reasonable and customary" charges to a fixed allowance schedule for medical services—to be updated periodically as cost increases warrant. You may recognize this as reversing what has become a common trend in health insurance plans.

Deductibles and coinsurance obligations are key features of cost-sharing in medical insurance plans. These, in our opinion, are disproportionately low—particularly in view of the tremendous increases in medical costs during recent years. As costs have risen, employee sharing in these costs has diminished to the point of insignificance. Without imposing unreasonable burdens on employees, we should see that they personally share more in the responsibility of decision making when buying medical care. Sharing more of the cost should result in more prudent buying.

To the extent possible, we would like to see our employees avoid expensive hospital stays—consistent, of course, with sound medical practice. Thus, we are now studying the feasibility of providing financial incentives to employees for selected second surgical opinions and for outpatient surgery in appropriate medical facilities. Also under study are other coverages provided on an outpatient basis as alternatives to treatment in acute care facilities.

To be sure, not all the attention to health care costs is new. The Bell System has, during recent years, moved to introduce a number of cost containment features in its medical plan coverage, such as voluntary second surgical opinion, preadmission testing, and outpatient coverage for minor surgery. We have long supported the concept of dual choice in health care. In fact, about 70,000 Bell System employees, 7% of our

work force, are enrolled in health maintenance organizations. Such organizations are still evolving toward their full potential, and deserve our support because of the promise they hold for providing cost effective medical care.

These changes in the design of benefit plans, as successful as they may be, only begin to scratch the surface. We are confident that there is much more to learn about health care utilization and the way we manage our health care dollars.

To address the question of health care utilization, we introduced—after considerable developmental effort—a medical insurance data system. By collecting and analyzing extensive data on claims, we are beginning to discern how insurance coverage is utilized by employees and their families. We shall have data for the first year of this effort analyzed within the next few months. This analysis should point us toward redesign of our insurance coverage, where needed, and changes in our administrative practices, where appropriate. The data will also permit dialogues with providers on such issues as the quality of care, hospital utilization, medical demographics, and cost.

Meanwhile, we are sharing information about our medical insurance data system with other interested groups. And we are participating in the work of a subcommittee on health of The Business Roundtable in an attempt to get its 160 member companies to consider using a similar medical data system. Most of the member companies have shown enthusiastic interest in such a system. Common sharing of information will enable the business community to have greater impact on the health care delivery system. If, for example, the largest five employers in a metropolitan area discover that hospital stays are prolonged unnecessarily by admissions on Fridays and Saturdays, their combined efforts could do something about the problem.

Another approach to health care cost containment may be found in employee health promotion. The Bell System and other corporations are supporting programs designed to prevent disease and to promote good health among employees. In this way we can reduce costs by keeping our people well and out of the hospital.

Now good judgment and intuition tell us that these programs are effective. But just how effective are they? To answer the skeptics, one of our divisions has undertaken a one-year study involving 1,600 employees in New Jersey and Missouri and a control group of 1,200 other employees. The study uses accepted techniques to assess individual and group

health risks. Also included is the measurement of employee attitudes and morale. Participants will be given the opportunity to enroll in various courses dedicated to such goals as smoking cessation, fitness, weight loss, high blood pressure control, care of the back, and cancer detection. The study will focus on the effect these programs have on changing self destructive lifestyles. We hope that the study will indicate substantial savings in medical expenses and improved employee health.

From our corporate point of view, we see that change in the economics of health care delivery is a current and urgent necessity. We welcome becoming a partner with the medical community in understanding how such change can be achieved. Certainly something more than modification in benefit plan design is required.

We also recognize the value of health promotion for the population at large as a way to promote employee well being, productivity, and, most important, to prevent sickness and disability. And in this regard we foster a working partnership between medicine and the business community.

How can medical schools help?

All sectors of society, of course, need to contribute to efforts to contain health care costs. But, owing to their pivotal position in our health care system, medical schools can play a decisive role in this effort. And, since the Academy has asked for our views, we do have a few ideas to offer that medical educators might want to consider.

First, it should be acknowledged that the existing techniques of medical education are obviously effective. As a country we are blessed with a profession that has won worldwide recognition for excellence. In many disciplines—including business—we have copied the medical profession's educational technique. Our attempt has been to emulate their teaching proficiency. We believe that medical schools can perform an educational service by contributing their immense intellectual reserves to the task of stabilizing the cost of health care. By virtue of their position, the medical schools and the nation's physicians can have a great impact on costs. Because of this, hope for change lies mainly with the profession itself.

While we are aware that the medical school curriculum already bulges at the seams, there is need to develop an awareness of health economics on the part of every physician. The economic consequences for each of their decisions, whether it be in the use of the simplest laboratory procedure or of some of the new and exciting high technology, should be considered. A curriculum could be devised on the economics of health care and incorporated into the already overcrowded training program. It

would address the medical-care cost crisis that faces the nation today and would enhance the student's awareness that medicine and economics are related. Certainly the curriculum should create a climate that makes cost-consciousness a basic element in the physician's approach to his practice.

It seems to us that if health care costs are to be contained, then the product of our medical education, the physicians themselves, must get into the process in a proactive way. If they do not, the important national goal of health care cost containment will go unachieved.

Medical schools, through their involvement with the nation's great teaching hospitals, can presumably set an example for the cost-effective use of diagnostic and treatment facilities by physicians and for the judicious use of high-cost technology.

Another suggestion is that some of the newer ideas about health promotion should become a part of the medical school curriculum. To the extent that they have not already done so, medical educators can seek ways to make disease prevention and health promotion basic to the practice of medicine.

Medical educators surely have already devoted a great deal of thought to both of these subjects and related issues. They are, I hope, high on the schools' agendas.

The achievements of America's medical schools in the 20th century have been truly remarkable. The improved quality of life that all of us now enjoy results in large measure from the accomplishments of their faculties and graduates. Our children and our grandchildren can look forward to even further advances. But they will not be inexpensive. This situation, perhaps, is our best incentive for making sure that we spend our health care dollars wisely today. If we can eliminate unnecessary expenditures from our collective medical bill, we shall be in a far better position to assure tomorrow's progress.